February 9, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /George M. Reeb/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Federal Reimbursement Claimed by North Carolina for Medicaid Personal Care Services Claims Submitted by Shipman Family Home Care, Inc. (A-04-09-04041)

Attached, for your information, is an advance copy of our final report on Medicaid personal care services claimed by Shipman Family Home Care, Inc. We will issue this report to the North Carolina Department of Health and Human Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov or Peter J. Barbera, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750 or through email at Peter.Barbera@oig.hhs.gov. Please refer to report number A-04-09-04041.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3141
Atlanta, GA 30303

February 14, 2011

Report Number: A-04-09-04041

Mr. Lanier M. Cansler
Secretary
North Carolina Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-2001

Dear Mr. Cansler:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Federal Reimbursement Claimed by North Carolina for Medicaid Personal Care Services Claims Submitted by Shipman Family Home Care, Inc.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Mark Wimple, Audit Manager, at (919) 790-2765, extension 24, or through email at Mark.Wimple@oig.hhs.gov. Please refer to report number A-04-09-04041 in all correspondence.

Sincerely,

/Peter J. Barbera/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF FEDERAL REIMBURSEMENT CLAIMED BY NORTH CAROLINA FOR MEDICAID PERSONAL CARE SERVICES CLAIMS SUBMITTED BY SHIPMAN FAMILY HOME CARE, INC.

Daniel R. Levinson
Inspector General

February 2011
A-04-09-04041

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

In North Carolina, the Department of Health and Human Services (the State agency) supervises the administration of the Medicaid program. Within the State agency, the Division of Medical Assistance (DMA) administers the Medicaid program. DMA's Facility and Community Care Section manages the personal care services program. Each beneficiary's physician is responsible for authorizing personal care services, and Medicaid-enrolled home care agencies provide service delivery. During the period July 1, 2005, through June 30, 2007, the State agency claimed personal care services expenditures totaling approximately $613 million ($391 million Federal share).

Pursuant to 42 CFR § 440.167, personal care services are generally furnished to individuals in their homes and not residing in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or institutions for mental diseases. Medicaid beneficiaries are authorized for personal care services by a physician in accordance with a plan of treatment or with a service plan approved by the individual State. Pursuant to North Carolina's administrative code, (1) the beneficiary of the service must have a medical diagnosis that warrants a physician's care and must be under the direct and ongoing care of the physician prescribing the services, (2) the beneficiary's medical condition must be stable, (3) services must be medically necessary, and (4) services must be provided by a State-licensed home care agency approved to provide in-home aide services. Examples of personal care services include cleaning, shopping, grooming, and bathing.

Shipman Family Home Care, Inc., is a private for-profit corporation located in Greensboro, North Carolina. The Greensboro location is 1 of 19 Shipman offices throughout North Carolina providing personal care services, and this location also functions as the administrative office for the corporation. We will refer to the Greensboro location as "Shipman" throughout this report. During the period July 1, 2005, through June 30, 2007, Shipman claimed personal care services expenditures totaling approximately $5.5 million ($3.5 million Federal share).

OBJECTIVE

Our objective was to determine whether the State agency ensured that Shipman's claims for Federal reimbursement of Medicaid personal care services complied with Federal and State requirements.

SUMMARY OF FINDINGS

The State agency did not ensure that all of Shipman's claims for Federal Medicaid reimbursement for personal care services met Federal and State requirements. Of the 100 sampled claim line items (items) in our random sample, 44 complied with Federal and State requirements, but 56 did not.

Of the 56 items that were not compliant, 24 contained more than 1 deficiency:

- For 33 items, services were not in accordance with the plan of care.
- For 19 items, there were no nursing visits for supervision and/or assessment.
- For 14 items, there was a lack of required documentation.
- For 12 items, the qualifications of the in-home care providers were not verified.
- For four items, there was no physician order.
- For one item, a family member provided services.

These deficiencies occurred because DMA did not have sufficient resources to adequately monitor Shipman's personal care services program for compliance with certain Federal and State requirements. The State agency has been working with the North Carolina legislature to develop new procedures and controls for the personal care services program. The North Carolina Current Operations and Capital Improvement Appropriations Act of 2009 funded an initiative effective July 1, 2009, which included legislatively mandated requirements for cost containment.

Based on our sample results, we estimated that the State agency improperly claimed $1,283,037 (Federal share) for unallowable personal care services during the period July 1, 2005, through June 30, 2007.

In addition to our sample review, we conducted interviews with 42 of the 86 beneficiaries in our sample of 100 items. The total number of beneficiaries was less than 100 because some beneficiaries had more than 1 sampled item. Of the 42 beneficiaries interviewed, 36 rated the quality of daily care as good or very good, 5 rated it as average, and 1 rated it as poor.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,283,037 to the Federal Government and
- continue its efforts to implement additional procedures and controls for monitoring the providers of personal care services for compliance with Federal and State requirements.

SHIPMAN FAMILY HOME CARE, INC., COMMENTS

In written comments on our draft report, Shipman acknowledged that some of its claims were noncompliant with applicable Federal and State laws and regulations governing the provision of personal care services; however, Shipman believed that these claims were anomalous and not representative of its general compliance efforts. Shipman provided information on the actions that it had taken in response to our audit findings.

Shipman's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Shipman's comments, we did not make any revisions to our findings. Before issuing our draft report, we discussed each of the deficiencies cited in the report with Shipman officials and provided Shipman the opportunity to provide additional, or alternative, documentation to support the sampled items. Shipman was unable to provide such support. We also obtained Shipman's verbal concurrence that 56 of the 100 items that we reviewed failed to meet Federal and State requirements for reimbursement of personal care services.

We do not concur that the 56 items were anomalous and not representative of Shipman's general compliance efforts. As discussed in the report, 24 of the 56 items (43 percent) contained more than 1 deficiency.

STATE AGENCY COMMENTS

The State agency concurred with all of our findings and found the recommendations to be both reasonable and appropriate. The State agency summarized its most recent actions to address fraud and abuse in the Medicaid In-Home Personal Care Services program.

The State agency's comments are included in their entirety as Appendix E.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

North Carolina's Medicaid Program

In North Carolina, the Department of Health and Human Services (the State agency) supervises the administration of the Medicaid program. Within the State agency, the Division of Medical Assistance (DMA) administers the Medicaid program. DMA uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims, including personal care service claims. The Federal Government's share of costs is known as the Federal medical assistance percentage (FMAP). From July 1, 2005, to September 30, 2005, the FMAP in North Carolina was 63.63 percent; from October 1, 2005, to September 30, 2006, the FMAP was 63.49 percent; and from October 1, 2006, to June 30, 2007, the FMAP was 64.52 percent.

North Carolina's Personal Care Services Program

North Carolina's personal care services program (the program) is managed by DMA's Facility and Community Care Section. Although DMA is responsible for the program, each beneficiary's physician is responsible for authorizing personal care services, and Medicaid-enrolled home care agencies arrange for service delivery. Title 10A § 13J.0901(29) of the North Carolina Administrative Code (NCAC) defines personal care services as including tasks that range from assistance to an individual with basic personal hygiene, grooming, feeding, and ambulation to medical monitoring and other health-care-related tasks. Pursuant to Title 10A NCAC § 22O.0120(a), such services must be medically necessary and the beneficiary must be under the direct and ongoing care of the physician prescribing the services. Further, the beneficiary of these services must have a medical diagnosis that warrants a physician's care, and the beneficiary's medical condition must be stable. During the period July 1, 2005, through June 30, 2007, the State agency claimed personal care services expenditures totaling approximately $613 million ($391 million Federal share).

Under North Carolina's State plan (Attachment 3.1-A.1, 23.f), a Medicaid beneficiary can receive up to 3.5 hours of personal care service a day and may not exceed 60 hours in a month. Those Medicaid beneficiaries who have personal care needs that exceed the service limitations can qualify to receive up to an additional 20 hours of service a month.

Shipman Family Home Care, Inc.

Shipman Family Home Care, Inc., is a private for-profit corporation located in Greensboro, North Carolina. The Greensboro location is 1 of 19 Shipman offices throughout North Carolina providing personal care services, and this location also functions as the administrative office for the corporation. We will refer to the Greensboro location as "Shipman" throughout this report. During the period July 1, 2005, through June 30, 2007, Shipman claimed personal care services expenditures totaling approximately $5.5 million ($3.5 million Federal share).

At the time of our audit, Shipman employed 259 in-home aides and provided personal care services to 290 Medicaid beneficiaries. The Director of Nursing and the Compliance Director were registered nurses (RN), and both were full-time employees whose duties were primarily administrative. Shipman contracted with two additional RNs who conducted beneficiary assessments, developed plans of care, and supervised the in-home aides.

Federal and State Requirements Related to Personal Care Services

The State agency and Shipman must comply with Federal and State requirements in determining whether beneficiaries are eligible for personal care services. Pursuant to section 1905(a)(24) of the Act and implementing Federal regulations (42 CFR § 440.167), personal care services must be (1) authorized for an individual by a physician in a plan of treatment or in accordance with a service plan approved by the individual State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home or, at the State's option, in another location.

Federal regulations at 2 CFR part 225 (incorporating Office of Management and Budget Circular A-87) establish principles and standards for determining allowable costs incurred by State and local governments under Federal awards. Section C.1.c. of Appendix A of 2 CFR part 225 provides that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations.

Title 10A of NCAC § 22O.0120 establishes coverage requirements for North Carolina's program. These requirements include that personal care services must be authorized by a physician and meet the following criteria: (1) the beneficiary of services must have a medical diagnosis that warrants a physician's care and must be under the direct and ongoing care of the prescribing physician, (2) the beneficiary's medical condition must be stable, (3) services must be medically necessary, and (4) services must be provided by a State-licensed home care agency approved to provide in-home aide services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency ensured that Shipman's claims for Federal reimbursement of Medicaid personal care services complied with Federal and State requirements.

Scope

Our audit period covered July 1, 2005, through June 30, 2007. Our sampling frame consisted of 132,650 claim line items (items) taken from North Carolina's Medicaid paid claims, totaling $5,525,548 ($3,528,156 Federal share), submitted by Shipman.

During our audit, we did not review the overall internal control structure of the State agency or Shipman. Rather, we limited our internal control review to the objective of our review.

From July through October 2009, we conducted fieldwork at the State agency's offices and the MMIS fiscal agent's office in Raleigh, North Carolina; Shipman's office in Greensboro, North Carolina; and physician offices and beneficiary residences located throughout the Greensboro, North Carolina, metropolitan area.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws and regulations, as well as State policy guidelines;

- held discussions with State agency officials to gain an understanding of the personal care services program;

- created a sampling frame of 132,650 items of personal care services greater than $28.79 that Shipman submitted for Medicaid reimbursement (Appendix A);

- selected a random sample of 100 items, for which we:

    - analyzed Medicare and Medicaid claim data to determine whether the beneficiary was residing in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases on the date of service;

    - analyzed Medicaid claim data to determine whether duplicate or prohibited services were performed on the date of service and whether daily or monthly service limits were exceeded;

    - reviewed Shipman's documentation supporting the item;

    - reviewed documentation from the physician ordering the personal care services to confirm whether a medical professional had examined the beneficiary before the order was signed; and

- visited the beneficiary, if available, associated with the item to inquire about the personal care services he or she received;[1] and

- estimated the unallowable Federal Medicaid reimbursement (Appendix B).

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not ensure that all of Shipman's claims for Federal Medicaid reimbursement for personal care services met Federal and State requirements. Of the 100 sampled items in our random sample, 44 complied with Federal and State requirements, but 56 did not. Of the 56 items, 24 contained more than 1 deficiency. The table summarizes the deficiencies noted and the number of items that contained each type of deficiency. See Appendix C for the results for each item.

Summary of Deficiencies in Sampled Items

Type of Deficiency	Number of Unallowable Items[2]
Services not in accordance with plan of care	33
No nursing visits for supervision and/or assessment	19
Lack of required documentation	14
Qualifications not verified	12
No physician order	4
Family member provided services	1

These deficiencies occurred because DMA did not have sufficient resources to adequately monitor Shipman's personal care services program for compliance with certain Federal and State requirements.

Based on our sample results, we estimated that the State agency improperly claimed $1,283,037 (Federal share) for unallowable personal care services from July 1, 2005, through June 30, 2007.

[1] Because of various reasons (e.g., the beneficiaries were deceased, declined to be interviewed, or could not be located), we were able to visit only 42 of the 86 beneficiaries. Some beneficiaries had more than 1 sampled item, and as a result, there were 86 beneficiaries in our sample of 100 items.

[2] The total exceeds 56 because 24 items contained more than 1 error.

SERVICES NOT IN ACCORDANCE WITH PLAN OF CARE

Pursuant to section 1905(a)(24)(A) of the Act, implementing Federal regulations (42 CFR § 440.167(a)(1)), and 10A NCAC § 13J.1107(a), personal care services must be provided in accordance with a physician-authorized plan of care.

For 33 of the 100 items in our sample, the services provided were not in accordance with the beneficiary's authorized plan of care. For 32 of the 33 items, Shipman did not provide either the type or duration of the services prescribed in the plan of care, as follows:

- For 28 items, Shipman failed to provide at least 1 of the tasks specified in the plan of care; however, it did not reduce its claim to reflect the actual services provided.

- For three items, Shipman claimed more units of service than prescribed in the plan of care; however, there was no documentation to support the deviation from the plan of care.

- For one item, Shipman provided services that were not included in the plan of care. The plan of care prescribed 9 hours of services per week (3 hours a day on Monday, Wednesday, and Friday). However, Shipman claimed an additional 3 hours of service on Thursday with no documentation to support the deviation from the plan of care.

For the remaining item, no plan of care covered the date of service. The physician determined that the beneficiary no longer required assistance and denied Shipman's request to authorize a plan of care for continued personal care services. Contrary to the physician's determination, Shipman failed to discontinue the services in a timely manner.

NO NURSING VISITS FOR SUPERVISION AND/OR ASSESSMENT

Pursuant to 10A NCAC § 13J.1110(d) and (f), an appropriate supervisor[3] must make a supervisory visit to each beneficiary's home at least quarterly, with or without the in-home aide present, and at least annually while the in-home aide is providing care to the beneficiary. The home care agency must maintain documentation of these visits.

Pursuant to 10A NCAC § 13J.1202, an appropriate professional must visit the beneficiary's home at least quarterly and assess the beneficiary's general condition, progress, and response to services provided and revise the plan of care if necessary based on the beneficiary's needs. Documentation of these visits shall be maintained in the beneficiary's service record. If the same professional is assigned responsibility for the quarterly assessment and supervision of the in-home aide, these functions may be conducted during the same home visit.

For 19 of the 100 items in our sample, Shipman failed to provide documentation that demonstrated supervision of the in-home aide, and, in 1 instance, Shipman did not demonstrate that a nursing assessment of the beneficiary's general condition had been performed.

[3] North Carolina's State plan requires that in-home aides work under the supervision of an RN (Attachment 3.1-A.1, 23.f.).

LACK OF REQUIRED DOCUMENTATION

Pursuant to section 1902(a)(27) of the Act and implementing Federal regulations (42 CFR § 433.32), Medicaid providers must maintain documentation that fully discloses the extent of the services provided to the beneficiary. The beneficiary's service records must contain a record of all services provided, including dates and times of the service, with entries dated and signed by the individual providing the service (10A NCAC § 13J.1402(a)(2)(C)).

Pursuant to 10A NCAC § 13J.1007(a), home care agencies must provide each beneficiary with a written notice of his or her rights and responsibilities before furnishing care or during the initial evaluation visit before the initiation of services. The home care agency is required to maintain documentation showing that beneficiaries were informed of their rights and responsibilities.

For 14 of the 100 items in our sample, Shipman lacked evidence that it had complied with 1 or more of the requirements detailed above. In all 14 items, at least 1 of the following deficiencies occurred:

- The service log for the date of service could not be located.
- The employee time record did not support the number of hours claimed.
- There was no evidence that the beneficiary was informed of his or her rights and responsibilities before the initiation of services.

QUALIFICATIONS NOT VERIFIED

Pursuant to section 1905(a)(24)(B) of the Act and implementing Federal regulations (42 CFR § 440.167(a)(2)), personal care services must be provided by an individual who is qualified to provide such services. In-home care providers who are not subject to occupational licensing laws can only be assigned care activities or tasks for which they have correctly demonstrated competency to an appropriate individual. The demonstration of competence for assigned care tasks or activities must be documented by the home care agency (10A NCAC § 13J.1110(b)).

Pursuant to the North Carolina General Statute § 131E-265, a home care agency's offer of employment to applicants who will fill positions that do not require an occupational license is conditioned on their consent to a criminal history record check. The home care agency must consider any convictions revealed by the criminal history record check when determining whether to hire the applicant.

For 12 of the 100 items in our sample, Shipman did not verify the qualifications of the individuals who provided in-home care. For seven of these items, there was no evidence that Shipman completed a criminal history record check of the in-home aide. For the remaining five items, there was no evidence that the in-home aide had demonstrated competency for all of the services provided.

NO PHYSICIAN ORDER

Pursuant to section 1905(a)(24)(A) of the Act, implementing Federal regulations (42 CFR § 440.167(a)(1)), and 10A NCAC § 22O.0120(a), personal care services must be authorized by a physician. Orders for personal care services must be signed by a physician, but care may commence in the interim with a verbal order. The home care agency must obtain the physician's signature within 60 days from the date of the verbal order (10A NCAC § 13J.1302(a) and (d)).

For 4 of the 100 items in our sample, Shipman did not obtain the proper physician's authorization. For three of these items, Shipman initiated personal care services before obtaining either a written or verbal order from the physician, and, in one instance, the physician subsequently denied the personal care services because the beneficiary did not qualify for benefits. For the remaining item, Shipman did not obtain the physician's signature within 60 days from the date of the verbal order.

FAMILY MEMBER PROVIDED SERVICES

Pursuant to section 1905(a)(24)(B) of the Act and implementing Federal regulations (42 CFR § 440.167(a)(2)), personal care services may not be provided by a member of the beneficiary's family. Title 10A NCAC § 22O.0410(c) states that a member of the beneficiary's immediate family may not be employed by a provider agency to provide reimbursable personal care services. Immediate family members are defined as spouses, children, parents, grandparents, grandchildren, and siblings and include corresponding step- and in-law relationships.

For 1 of the 100 items in our sample, an immediate family member provided the personal care services. Shipman's files contained documentation that the in-home aide was the beneficiary's mother. Both the in-home aide and the beneficiary confirmed the family member relationship.

CAUSE OF UNALLOWABLE ITEMS

These deficiencies occurred because DMA did not have sufficient resources to adequately monitor Shipman's program for compliance with certain Federal and State requirements. In June 2006, the State agency implemented a program of limited onsite monitoring visits (15 home care agencies each month) to review the case records for compliance with Federal and State requirements. The program also included beneficiary interviews and quarterly regional training. However, because of the substantial growth in North Carolina's personal care services program, the State agency's limited monitoring efforts were inadequate.

The State agency has worked with the North Carolina legislature in developing new procedures and controls for the program. The North Carolina Current Operations and Capital Improvement Appropriations Act of 2009 (Session Law 2009-451) funded an initiative effective July 1, 2009, which included mandated requirements for cost containment. At the outset of this initiative, an independent contractor reassessed and reauthorized personal care services for approximately 37,600 program participants. The restructured program includes involvement by the beneficiary's physician, independent assessments, and independent review of the plans of care to

ensure the appropriate utilization of personal care services. The program provides for automated tools and includes consistency among the assessments, service authorizations, plans of care, provider service logs, and claims for reimbursement.

ESTIMATION OF THE UNALLOWABLE AMOUNT

Of the 100 personal care services items sampled, 56 items were not in compliance with Federal and State requirements. Based on our sample results, we estimated that the State agency improperly claimed $1,283,037 (Federal share) for unallowable personal care services during the period July 1, 2005, through June 30, 2007. The details of our sample results and estimates are shown in Appendix B.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,283,037 to the Federal Government and

- continue its efforts to implement additional procedures and controls for monitoring the providers of personal care services for compliance with Federal and State requirements.

SHIPMAN FAMILY HOME CARE, INC., COMMENTS

In written comments on our draft report, Shipman acknowledged that some of its claims were noncompliant with applicable Federal and State laws and regulations governing the provision of personal care services; however, Shipman believed that these claims were anomalous and not representative of its general compliance efforts. Shipman provided information on the actions that it had taken in response to our audit findings.

Shipman's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Shipman's comments, we did not make any revisions to our findings. Before issuing our draft report, we discussed each of the deficiencies cited in the report with Shipman officials and provided Shipman the opportunity to provide additional, or alternative, documentation to support the sampled items. Shipman was unable to provide such support. We also obtained Shipman's verbal concurrence that 56 of the 100 items reviewed failed to meet Federal and State requirements for reimbursement of personal care services.

We do not concur that the 56 items were anomalous and not representative of Shipman's general compliance efforts. As discussed in the report, 24 of the 56 items (43 percent) contained more than 1 deficiency.

STATE AGENCY COMMENTS

The State agency concurred with all of our findings and found the recommendations to be both reasonable and appropriate. The State agency summarized its most recent actions to address fraud and abuse in the Medicaid In-Home Personal Care Services program.

The State agency's comments are included in their entirety as Appendix E.

OTHER MATTER

We interviewed 42 of the 86 beneficiaries in our sample to determine whether quality-of-care issues existed and whether any service-related problems existed.[4] We did not interview the 44 remaining sampled beneficiaries because they declined to be interviewed, could not be located, or were deceased. Of the 42 beneficiaries interviewed, 36 rated the quality of daily care as good or very good, 5 rated it as average, and 1 rated it as poor.

Of the 42 beneficiaries interviewed, 16 stated that they had experienced an issue with the performance or professionalism of in-home aides at some point while receiving care from Shipman; however, Shipman resolved these issues to the satisfaction of the beneficiaries.

[4] The total number of beneficiaries is less than 100 because some beneficiaries had more than 1 sampled item.

APPENDIXES

APPENDIX A: SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicaid paid claims for personal care services provided by the Greensboro location of Shipman Family Home Care, Inc. (Shipman), during the period July 1, 2005, through June 30, 2007, that the North Carolina Department of Health and Human Services claimed for Federal Medicaid reimbursement.

SAMPLING FRAME

The sampling frame consisted of 132,650 claim line items totaling $5,525,548 ($3,528,156 Federal share) for personal care services provided by Shipman during our audit period.

SAMPLING UNIT

The sampling unit was a personal care service claim line item.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 claim line items.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used OIG/OAS statistical software to estimate the unallowable payments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Frame Size	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Items	Value of Unallowable Items
132,650	$3,528,156	100	$2,608	56	$1,181

Estimates of Unallowable Items
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$1,566,109
Lower limit	1,283,037
Upper limit	1,849,181

APPENDIX C: RESULTS FOR EACH SAMPLED ITEM

Legend

A	Services not in accordance with plan of care
B	No nursing visits for supervision and/or assessment
C	Lack of required documentation
D	Qualifications not verified
E	No physician order
F	Family member provided services

OIG Review Determinations for the 100 Sampled Items

Item Number	A	B	C	D	E	F	Number of Errors
1	X						1
2							0
3	X						1
4	X		X				2
5							0
6							0
7							0
8	X	X					2
9	X						1
10		X					1
11	X		X				2
12				X			1
13							0
14			X				1
15							0
16				X			1
17		X		X			2
18	X		X				2
19	X		X				2
20	X		X				2
21	X						1
22					X		1
23				X			1
24				X			1
25							0
26							0
27							0
28							0
29	X						1
30	X	X					2

Item Number	A	B	C	D	E	F	Number of Errors
31	X						1
32	X		X				2
33	X	X					2
34							0
35	X						1
36		X					1
37							0
38							0
39		X					1
40							0
41	X						1
42							0
43							0
44							0
45							0
46		X					1
47							0
48		X			X		2
49					X		1
50	X	X		X			3
51							0
52							0
53							0
54							0
55							0
56		X					1
57							0
58	X	X					2
59	X			X			2
60							0
61							0
62							0
63							0
64							0
65							0
66				X			1
67							0
68							0
69	X			X			2
70	X						1
71							0
72							0

Item Number	A	B	C	D	E	F	Number of Errors
73							0
74							0
75							0
76							0
77	X						1
78							0
79	X						1
80							0
81	X						1
82							0
83			X	X			2
84		X	X	X			3
85	X		X				2
86	X		X				2
87							0
88	X	X	X				3
89							0
90	X		X				2
91		X					1
92		X	X				2
93	X						1
94		X					1
95						X	1
96		X		X			2
97	X						1
98	X						1
99	X	X					2
100					X		1
	33	19	14	12	4	1	
Total With Errors							56
Total With More Than One Error							24

APPENDIX D: SHIPMAN FAMILY HOME CARE, INC., COMMENTS

Shipman Family Home Care, Inc.
1614 East Market Street
Greensboro, North Carolina 27401

September 10, 2010

Peter J. Barbera
Office of Audit Services, Region IV
Office of Inspector General
U.S. Department of Health and Human Services
61 Forsyth Street, SW, Suite 3T41
Atlanta, Georgia 30303

Re: Shipman Family Home Care, Inc.
Report Number A-04-09-04041

Dear Mr. Barbera:

On behalf of Shipman Family Home Care, Inc. ("SFHC"), I am writing in response to your letter dated July 28, 2010 regarding Report Number A-04-09-04041. As you requested, this letter will set forth SFHC's written comments in response to the U.S. Department of Health and Human Services Office of Inspector General ("OIG") draft report entitled *Review of Federal Reimbursement Claimed by North Carolina for Medicaid Personal Care Services Claims Submitted by Shipman Family Home Care, Inc.* (the "Draft Report").

I. BACKGROUND

SFHC is a North Carolina corporation enrolled with the North Carolina Department of Health and Human Services Division of Medical Assistance ("DMA") to provide services to Medicaid recipients, among other consumers, including, without limitation, Personal Care Services to consumers requiring such services. From July through October 2009, OIG conducted an audit of 100 claims paid by DMA for Personal Care Services provided by SFHC between July 1, 2005 and June 30, 2007. OIG found that 56 of the 100 claims reviewed failed to meet State and Federal requirements for reimbursement of Personal Care Services. In the Draft Report, OIG alleged that the audited claims had the following deficiencies: (a) services not in accordance with plan of care; (b) no nursing visits for supervision and/or assessment; (c) lack of required documentation; (d) qualifications not verified; (e) no physician order; and (f) family member provided services.

II. SFHC'S RESPONSE

SFHC is dedicated to providing high-quality, timely, and efficient health care services to eligible North Carolina Medicaid beneficiaries. In providing Personal Care Services, SFHC endeavors to comply with all applicable requirements set forth in DMA Clinical Coverage Policy

No. 3C: Personal Care Services (the "PCS Policy"), as well as all other State and Federal laws governing the provision of Personal Care Services to Medicaid beneficiaries. Furthermore, SFHC makes every effort to ensure that all employees and staff are adequately trained and knowledgeable with regard to Medicaid coverage requirements for such services.

In response to the specific deficiencies cited by OIG in the Draft Report, SFHC shows the following:

1. Compliance with Plan of Care

SFHC acknowledges that some, but not all, of the claims identified by OIG included services not provided in accordance with the patient's Plan of Care. The claims subject to OIG's audit were provided by SFHC between July 1, 2005 and June 30, 2007. In November 2005, DMA significantly revised the PCS Policy, which included changes to the documentation requirements for Personal Care Services. Although SFHC made every effort to train its employees and staff on the new PCS Policy requirements, SFHC believes that many of the deficiencies cited by OIG were the result of documentation errors caused by the transition to the revised PCS Policy. Therefore, SFHC believes that these claims are anomalous and not representative of SFHC's general compliance efforts.

As a result of OIG's audit, however, SFHC has taken measures to reassess its compliance strategy to ensure that all Personal Care Services are provided in accordance with the PCS Policy. Specifically, as required under Section 7.7 of the PCS Policy, prior to initiating Personal Care Services, SFHC develops a Plan of Care for each beneficiary. The Plan of Care is documented on the last page of the Physician Authorization for Certification and Treatment ("PACT") form. SFHC will make every effort to ensure that all Personal Care Services provided to a beneficiary are designed to meet the beneficiary's personal care needs as identified on the beneficiary's PACT form, and that all services required under the Plan of Care are provided as ordered. In that regard, SFHC has revised its Service Log forms so that staff members providing Personal Care Services can more accurately verify that services are provided in accordance with the Plan of Care.

2. Nursing Visits

Section 7.9 of the PCS Policy states that "[t]he RN clinical supervisor representing the PCS provider must conduct a supervisory visit in the recipient's home with the recipient present within 90 days of the initial assessment visit and at least every 90 days thereafter." SFHC strives to ensure that nurse supervision visits are conducted in accordance with the PCS Policy, and that all nurse supervision visits are documented on the "In-Home Supervisory Visit Report" and maintained in the beneficiary's medical record.

SFHC acknowledges that some of the claims identified by OIG failed to include documentation of nursing visits for supervision and/or assessment. SFHC believes that these

claims are anomalous and not representative of SFHC's general compliance efforts. Nevertheless, SFHC has taken measures to reassess its compliance strategy to ensure that all Personal Care Services are provided in accordance with the PCS Policy, including, without limitation, ensuring that nursing visits are performed and documented in a timely fashion.

3. Required Documentation

SFHC makes best efforts to maintain all required documentation necessary to bill Medicaid for Personal Care Services. For each service, SFHC strives to ensure that the beneficiary's medical record includes: (a) physician orders for the initial assessment, initiation, and continuation of Personal Care Services; (b) the PACT form and Plan of Care; (c) documentation of any required beneficiary reassessments; (d) nurse supervision reports; (e) service logs for each date of service in which Personal Care Services are provided; and (f) documentation that the beneficiary has been informed of his or her rights prior to the initiation of Personal Care Services. Furthermore, SFHC maintains records verifying the qualifications and credentials of all individuals providing Personal Care Services on behalf of SFHC.

SFHC acknowledges that some of the claims identified by OIG failed to include adequate documentation for the billing of Personal Care Services. While SFHC believes that these claims are anomalous and not representative of SFHC's general compliance efforts, SFHC has taken measures to reassess its compliance strategy to ensure that all Personal Care Services are provided and documented in accordance with the PCS Policy.

4. Staff Qualifications

SFHC maintains records verifying the qualifications and credentials of each of its staff members, and all individuals providing Personal Care Services on behalf of SFHC are qualified to provide such services in accordance with Section 6.0 of the PCS Policy.

SFHC acknowledges, however, that some of the claims identified by OIG failed to include adequate documentation verifying the qualifications and credentials of SFHC's staff members. SFHC believes that these claims are anomalous and not representative of SFHC's general compliance efforts. Nevertheless, SFHC has taken measures to reassess its compliance strategy to ensure that all Personal Care Services are provided in accordance with the PCS Policy, including, without limitation, maintaining documentation of each staff member's qualifications and credentials.

5. Physician Orders

As required under Sections 7.1 and 7.2 of the PCS Policy, SFHC obtains physician orders for the initial assessment, initiation, and continuation of all Personal Care Services. These orders are maintained in each beneficiary's medical record.

SFHC acknowledges that some of the claims identified by OIG failed to include adequate documentation of physician orders for the initial assessment, initiation, and continuation of Personal Care Services. SFHC believes that these claims are anomalous and not representative of SFHC's general compliance efforts. However, as a result of OIG's audit, SFHC has taken measures to reassess its compliance strategy to ensure that all Personal Care Services are provided in accordance with the PCS Policy, including, without limitation, confirming that physician orders are properly documented.

6. Service Provided by Family Member

OIG identified one claim in which a beneficiary's immediate family member provided the Personal Care Services in question. SFHC believes that this claim is anomalous and not representative of SFHC's general compliance efforts. Specifically, at the time of employment, SFHC requires each employee to sign an acknowledgement form attesting that he or she is not an "immediate family member" of any SFHC client, as such term is defined in 10A N.C.A.C. 22O.0410(c). Although the employee in question completed such an attestation, SFHC subsequently discovered that the employee had lied; the employee was in fact related to a SFHC client. As a result of this incident, the employee in question was terminated. Furthermore, SFHC now requires employees who have the same last name as any SFHC client to submit a birth certificate verifying that the employee and client are not related.

III. CONCLUSION

As discussed in detail above, SFHC acknowledges that some, but not all, of the claims identified by OIG failed to comply with applicable State and Federal laws and policies governing the provision of Personal Care Services to Medicaid beneficiaries. While SFHC believes that these claims are anomalous and not representative of SFHC's general compliance efforts, SFHC has taken measures to reassess its compliance strategy to ensure that all Personal Care Services are provided in accordance with such laws and policies.

Please feel free to contact me with any questions or comments.

With best regards.

Sincerely,

Gladys F. Shipman, Director

cc: Sean A. Timmons, Esq.

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APPENDIX E: STATE AGENCY COMMENTS

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

November 19, 2010

Mr. Peter J. Barbera
Regional Inspector General for Audit Services
Office of Audit Services, Region IV
Office of Inspector General
U.S. Department of Health and Human Services
61 Forsyth Street. SW, Suite 3T41
Atlanta, GA 30303

RE: Report A-04-09-04041

Dear Mr. Barbera:

The Department has received the draft report referenced above and I have distributed it to key individuals in Medicaid Clinical Policy and Programs, Medicaid Program Integrity, and Medicaid Audit Sections for review and comment.

Please be advised that the Department concurs with all of the report findings and finds the recommendations contained therein to be both reasonable and appropriate. Since this report covers the period July 1, 2005, to June 30, 2007, I would take this opportunity to summarize the Department's more recent actions to address fraud and abuse in the Medicaid in-home Personal Care Services (PCS) program.

PCS Program Review and Restructuring

1. During the period April 2007 to March 2009, Medicaid conducted 347 on-site home care provider audits and interviewed 4,273 randomly selected PCS recipients served by these agencies in their homes. These reviews were conducted by Registered Nurses experienced in home care services. The purpose of this review was to determine if home care agencies were in compliance with program requirements, if recipients demonstrated the level of functional disability documented in their provider assessment forms, and if recipients were satisfied with the services provided by their PCS provider. A final report of program abuses was submitted to the North Carolina General Assembly in April of 2009.

2. The State Budget for SFY 2010 (SL 2009-451) addressed program abuses identified in this review by mandating that:

   a. All current PCS recipients have their assessments reviewed for medical necessity and program compliance. The service level of each PCS recipient is adjusted by

Medicaid based on this review. To date, Medicaid has computerized and reviewed over 62,000 provider assessment forms for participants receiving PCS in 2009 and 2010; however, an administrative court judge blocked the state from making service level adjustments without a face-to-face assessment.

b. Medicaid implement independent assessment by an entity that does not provide PCS for all recipients requesting admission to PCS, continuation of PCS beyond the service authorization end date, and change of status review. This program was fully implemented in April 2010 and, to date, the contract Independent Assessment Entity has conducted over 12,000 independent PCS assessments.
c. Services provided by in-home aides focus on hands-on assistance to recipients, as determined by their assessment. Nonmedical transportation, errand-running, shopping, money management, and guiding and coaching were eliminated from the list of covered services.
d. Referring physicians attest to the medical necessity of the requested PCS.

3. As part of the independent assessment process, Medicaid established an electronic interface between the IA management system and the MMIS to ensure that PCS provider claims were paid in accordance with the number of approved PCS hours for each recipient.
4. In 2010, the State Budget for SFY 2011 (SL 2010-31) included additional legislatively-mandated changes to the In-Home PCS Program. If approved by CMS, Medicaid will:

   a. Transition qualified PCS participants from the existing program to two new programs: one for children and their families and one for adults who are functionally disabled. The new program for children will provide a broader scope of benefits directed to the needs of children and their families. The new program for adults will focus on recipients who have the highest level of functional disability and most at risk for placement in a nursing or assisted living facility.
   b. Continue independent assessment for both PCS programs.
   c. Expand the use of the automated program management system to better manage the cost, quality, and utilization of PCS.

The PCS reviews and data generated by the independent assessment program have enabled Medicaid to identify and address problems with the PCS program and to identify home care agencies that are not complying with program requirements. The implementation of independent assessment ensures that all assessments are valid and reliable and PCS providers furnish services in amounts appropriate to the needs of each recipient. Independent assessment is expected to significantly reduce medically unnecessary and excessive PCS.

PCS Audits, Pre-, and Post Payment Reviews

The Medicaid Audit Section is currently conducting post-payment desk reviews of services provided by randomly selected Shipman sites. These reviews addressed services provided by this agency between January 1 and June 30, 2008. Two audits have been completed; one has been issued and is under appeal. The second is in review.

The Medicaid Program Integrity Section has initiated increased surveillance and review of home care agencies, including putting three extra audit teams in the field. Home care agencies identified as being out of compliance by the on-site and provider assessment reviews, as detailed in 1 above, have been targeted for follow-up audits.

Twelve of these home care agencies, including the Shipman Agency, have been selected and are scheduled for pre-payment reviews of all claims that will include submission of supporting documentation to justify all charges for services provided.

The North Carolina Department of Health and Human Services is committed to providing quality care and services to all recipients, as well as eliminating waste and abuse in Medicaid programs and services. We will use the information in this report to take appropriate actions to correct these deficiencies in this agency and continue to implement procedures and controls for monitoring providers of personal care services, as recommended in the report.

Sincerely,

Lanier M. Cansler